VERMONT

State of Vermont
Department of Health
Children with Special Health Needs
108 Cherry Street -- PO Box 70
Burlington, VT 05402-0070
HealthVermont.gov

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Agency of Human Services

Authorization to Disclose Health Information

I, _____ hereby authorize
(Parent, Legal Guardian, or Patient if 18 or older and representing self)

Provider/agency name _____

Provider/Agency address _____

_____

to disclose to Vermont Department of Health, Children with Special Health Needs (CSHN) pertinent medical, educational, social, or mental health records, X-rays, and/or screening reports **for the purpose of providing evaluation and/ or treatment services**.

Regarding _____ _____
(Name of Patient) (Date of Birth)

Treatment or other services are not conditioned upon my authorizing this disclosure. Further, I may revoke this authorization at any time except to the extent that CSHN has already acted in reliance on it. In general, revocation must be submitted in writing and sent to CSHN at this address: Vermont Department of Health-CSHN, P.O. Box 70, Burlington, VT 05402

Means of Disclosure (check all that apply): ___Written ___Oral ___Electronic ___Audio Tape

Date upon which this authorization will expire: _____. If no date is noted, expiration is one (1) year from date it is signed.

Signature of Parent or Legal Guardian: _____Date: _____

Printed name: _____

Relationship to Patient: _____

Witness (age 18 older): _____**Date**: _____
(Signature and Title)

I hereby revoke this authorization on _____(date) at _____(time). Do not release any further information under this authorization.

Signature: _____